

GENERAL

1.0. PURPOSE

The purpose of the following TRICARE claims processing procedures is to help ensure that all claims for care received by TRICARE beneficiaries are processed in a timely and consistent manner and that government-furnished funds are expended only for those services or supplies authorized by law and Regulation. The contractor must review all claims submitted. This review must ensure that sufficient information is submitted to determine:

- 1.1. The patient is eligible.
- 1.2. The provider of services or supplies is authorized under the TRICARE Program.
- 1.3. The service or supply provided is a benefit.
- 1.4. The service or supply provided is medically necessary and appropriate or is an approved TRICARE preventive care service.
- 1.5. The beneficiary is legally obligated to pay for the service or supply (except in the case of free services).
- 1.6. That the claim contains sufficient information to determine the allowable amount for each service or supply.

NOTE: Throughout this chapter, where the word “beneficiary” is used with respect to a required action, it is to be understood that the spouse, parent or legal guardian of a minor or incompetent beneficiary may act in behalf of that person, unless there is a specific requirement to the contrary in the text.

2.0. WHO MAY FILE A CLAIM

Any TRICARE eligible beneficiary may submit a claim. Any individual who meets the requirements for eligibility under TRICARE, as determined by one of the Uniformed Services, may file a claim. Any institutional or individual professional provider approved under TRICARE may file a claim on a participating basis for services or supplies provided to a beneficiary and receive payment directly from TRICARE.

2.1. State Agencies

A state agency which administers the Medicaid Program may submit a claim, if there has been an agreement signed between the agency and TRICARE Management Activity (TMA). (Refer to the *TRICARE Reimbursement* Manual, *Chapter 1, Section 21.*)

2.2. Claims Submittal Charges

The contractor shall deny any charge imposed by the provider relating to completing and submitting the applicable claim form (or any other related information). Such charges shall not be billed separately to the beneficiary by the provider nor shall the beneficiary pay the provider for such charges. These charges are to be reported as noncovered charges and denied as such.

2.3. Participating Provider - Agency Agreement With A Third Party

Occasionally, a participating provider may enter into an agency agreement with a third party to act on its behalf in the submission and the monitoring of third party claims, including TRICARE claims. Such arrangements are permissible as long as the third party is not acting simply as a collection agency. There must be an agency relationship established in which the agent is reimbursed for the submission and monitoring of claims, but the claim remains that of the provider and the proceeds of any third party payments, including TRICARE payments, are paid to the provider. The contractor can deal with these agents in much the same manner as it deals with the provider's accounts receivable department. However, such an entity is not the provider of care and cannot act on behalf of the provider in the filing of an appeal unless specifically designated as the appealing party's representative in the individual case under appeal. Questions relating to the qualifications of any such business entity should be referred to the TMA Office of General Counsel for resolution.

3.0. TRICARE CLAIM FORMS

3.1. Confidentiality

TMA and the TRICARE contractor shall hold the information confidential except when:

3.1.1. Disclosure is specifically authorized by the beneficiary.

3.1.2. Disclosure is necessary to permit authorized government officials to investigate and prosecute criminal actions.

3.1.3. Disclosure is specifically authorized or required under the terms of the Privacy Act or Freedom of Information Act. TMA and TRICARE contractors may, without consent or notice to a beneficiary, release to or obtain from any insurance company or other organization, governmental agency, provider or person any information with respect to any beneficiary when such release constitutes a routine use duly published in the **Federal Register** in accordance with the Privacy Act (5 U.S.C. 522a).

3.2. Acceptable Claim Forms

A properly completed acceptable claim form must be submitted to the contractor before payment may be considered. The contractor shall accept the following claim forms for TRICARE benefits: The DD Form 2520 (only for services rendered in foreign countries), the DD Form 2642 (see [Figure 8-A-1](#)), the HCFA 1500, and the UB-92.

3.2.1. DD Form 2642, "Patient's Request For Medical Payment" (Figure 8-A-1)

This form is for beneficiary use only and is for submitting a claim requesting payment for services or supplies provided by civilian sources of medical care. Those include physicians, pharmacies, medical suppliers, medical equipment suppliers, ambulance companies, laboratories, Program for Persons with Disabilities providers, vendor pharmacies, or other authorized providers. If a DD Form 2642 is identified as being submitted by a provider for payment of services, the form shall be returned to the provider with an explanation that the DD Form 2642 is for beneficiary use only and that the services must be resubmitted using either the HCFA 1500 or the UB-92, whichever is appropriate. The new form may be used for services provided in a foreign country but only when submitted by the beneficiary. The DD Form 2520 will continue to be used by foreign providers and by beneficiaries receiving medical care in foreign countries. Contact the TMA Administrative Office to order the DD Form 2642.

3.3. Laser Printed Or Pin-Fed Versions Of The TRICARE Forms

Laser printed or pin-fed and other versions of TRICARE forms that do not contain the certification and Privacy Act information on the reverse side of the claim form are not to be accepted and technically should be returned to the provider or beneficiary with instructions to file on an approved version of the claim. A provider may file with the contractor a certification that he/she will fully comply with the certification's terms and conditions on the reverse of the claim form. However, in the absence of any indication to the contrary during normal claims receipt and processing, contractors shall assume the proper authorization is on file for processing the claim. In the contractor's quality control audit and program integrity samples, the contractor shall validate through file checks, those claims, which were filed using laser printed, pin-fed or other versions of the TRICARE-approved forms, that the proper authorization was on file at the time the claim was processed. The contractor should remind providers of the requirement for submitting their claims on the correct form or requesting an exception through at least annual notice in routine bulletins or newsletters and at other appropriate times when contracts are made such as renewal of provider participation agreements. The following format shall be incorporated into a letter from an authorized provider representative and kept on file at the contractor:

"I am the **(Title or Position)**, an authorized representative of **(Name of Provider)**, with the authority to file and certify TRICARE claims on behalf of **(Name of Provider)**."

"I have read and understand the terms, certifications, and conditions contained on both sides of TRICARE claim form **(Number of Form)** and certify that **(Name of Provider)** will fully comply therewith in the filing of a participating TRICARE claim."

